

THE STANDARD OF CARE IN MEDICAL PRACTICE AND DISCLOSURE OF TREATMENT RISK TO PATIENTS - AN INTERNATIONAL PERSPECTIVE

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INTRODUCTION

Common law jurisdictions throughout the world continue to develop medical jurisprudence and Malaysia, in common with Ireland and the United Kingdom, is no exception. The theme of this review paper pertains to the legal standards for due care and skill of the medical profession in its diagnosis and treatments of patients and how this is balanced with the patient's right to know as expressed in the law relating to disclosure of risks in such diagnosis and treatment.

THE LAW IN ENGLAND

The starting point for modern medical jurisprudence on disclosure of risk is the statement of McNair J in the 1957 case of *Bolam v Friern Hospital Management Committee* (1957 2 all ER 118). The "*Bolam*" test was stated thus:

"a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

This *Bolam* principle has been accepted in English law as applying to both treatment and diagnosis in the cases of *Whitehouse v Jordan* (1981) 1 WLR 246 and *Maynard v West Midland Regional Health Authority* (1984) 1 WLR 634.

In another landmark decision of the House of Lords in *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 All ER 643 in which the appellant patient's appeal was dismissed. Bridge LJ commenting on the issue of non-disclosure said that it was an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test. But he further stated "but I do not see that this approach involves the necessity to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty". Scarman LJ in his judgement addressed the patient's right of self-determination. In an interesting observation on whether or not English law should recognise the rule of informed consent, he stated: "the common law is adaptable: it would not otherwise have survived over the centuries of its existence". He went on to say: "unless statute has intervened to restrict the range of judge made law, the common law enables the judges, when faced with the situation where a right recognised by law is not adequately protected, either to extend existing principles to cover the situation or to apply an existing remedy to redress the injustice. There is here no novelty: but merely the application of the principle '*ubi jus ibi remedium*'." Scarman LJ considered the American and Canadian cases of *Canterbury v Spence* (1972) 464 F2d772 and *Reibl v Hughes* (1980) 114 DLR (3d)1 which explored the parameters of the "prudent patient" test.

Diplock LJ in his judgement included the following: "*those members of the public who seek medical or surgical aid will be badly served by the adoption of any legal principle that would confine the doctor to some long established, well tried method of treatment only, although its past record of success might be small, if he wanted to be confident that he would not run the risk of being held liable in negligence simply because he tried some more modern treatment, and by some unavoidable mischance it failed to heal but did some harm to the patient. This would encourage "defensive medicine" with a vengeance*".

The law of medical negligence and disclosure of risk in England was developed further in the 1997 case of *Bolitho v City and Hackney Health Authority* (1997) 3 WLR 1151. In this case, again the appellant patient's appeal was dismissed. Browne-Wilkinson LJ in his judgement said: "in the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of

withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible”.

There has been some further development in English law in this area in the case of *Chester v Afshar* in 2005. Hope LJ addressed the issue of causation in consent. He appeared to move from the “but for” test of causation by accepting that an injury is within the scope of the doctor’s duty to inform and therefore by not informing the patient of such injury, it could be said to have caused the injury. This case has again advanced the law in England and has made it clear that a doctor has a duty to inform a patient of significant adverse outcome, or risks or complications, from a medical procedure.

THE LAW ELSEWHERE IN THE COMMON LAW WORLD

The seminal case of *Rogers v Whitaker* (1992) 175 CLR 479 has had enormous influence on the development of medical jurisprudence in disclosure of risks throughout the common law world. Mason CJ considered *Bolam* and *Sidaway* in the UK and the case of *Reibl* in Canada. He quoted from the Canadian case thus: “*the issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient’s right to know what risks are involved in undergoing or foregoing certain surgery or other treatment*”. Mason CJ stated “*there is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient*”. In a very pertinent observation in his judgement he said “*the duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a single comprehensive duty. However, the factors according to which a Court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors.*” He further stated that “*the law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach a significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it*”. In the particular case the appellant doctor lost his appeal. Central to this outcome was the fact that the patient had made clear her great concern that no injury should befall her one good eye. The judges were satisfied that it would be

reasonable for a person with one good eye to be so concerned about the possibility of injury to that eye from a procedure which was elective.

In essence, the *Rogers* case was more patient centred with a greater recognition of patient self-determination than English law had previously applied. Indeed, *Bolitho*, which was chronologically after the judgement in *Rogers*, was still more doctor centred with a rare exception. Indeed Gaudron J in the *Rogers* case stated that “*even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as ‘the Bolam test’*”.

It was commonly understood that the *Rogers* case might only apply to cases where there was a question of negligent advice only. However, the Australian High Court case of *Naxakis v Western General Hospital and Another* (1999) 162 ALR 540. McHugh J made it clear that the *Rogers* approach applied also to treatment. He stated “*in Rogers v Whitaker, this Court rejected the Bolam test and held that a finding of medical negligence may be made even though the conduct of the defendant was in accord with the practice accepted at that time as proper by a responsible body of medical opinion*”. I will return to this case later in this paper as it may have significance in the development of this area of medical jurisprudence in Malaysia.

It is however to be noted that not all common law jurisdictions have moved away from *Bolam* to *Rogers*. In Singapore in the Court of Appeal, Yong Pung How CJ considered in great detail the *Bolam* principle in the case of *Dr. Khoo James & Anor v Gunapathy d/o Munandy* (2002) 2SLR 414. He said: “*In determining whether a doctor has breached the duty of care owed to his patient, a judge will not find him negligent as long as there is a respectable body of medical opinion, logically held, that supports his actions.*” The judgment referred to the legal principle in *Bolam* as “*this time honoured test of liability*”. However, the reference to the opinion “logically held” should be noted and the judgment whilst affirming that the *Bolam* test applied to the issue of advice said that “*Bolitho presented a timely addendum to the Bolam test*”. Their Lordships, however, also recognised with admirable humility that “*at the heart of the Bolam test is the recognition that judicial wisdom has its limits*”.

THE LAW IN IRELAND

In Ireland the landmark case of *Dunne (an infant) v the National Maternity Hospital and Jackson* (1989) IR 91 set out the law on the appropriate standard of medical care in that jurisdiction. In that case Finlay CJ stated that “if a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration”. The principles of medical negligence in Ireland as applied to the duty of disclosure was explored in great detail in the case of *Geoghegan v Harris* (2000) 3 IR 536. In that case Kearns J considered not only the principles in *Dunne* but also the judgements of the Supreme Court judges in *Walsh v Family Planning Services Limited and Others* (1992) 1 IR 496 together with the US and Canadian cases of *Canterbury* and *Reibl* respectively. He stated that an analysis of these judgements yields the same answers in relation to two critical questions, that is to say “ (a) the requirement on a medical practitioner is to give a warning of any material risk which is a “known complication” of an operative procedure properly carried out. (b) the test of materiality in elective surgery is to enquire only if there is any risk, however, exceptional or remote, of grave consequences involving severe pain stretching for an appreciable time into the future”. Kearns J in a reference to a renowned Irish academic jurist, Mr. John Healy, quotes the latter as saying “the Courts have recognised the institutional reality that they retain at the very least a residual power to override expert opinion, even where that opinion unanimously supports the defendants propositions. The Irish Courts considerably more pragmatic in this regard have repeatedly acknowledged this to be so”.

In the Irish Supreme Court decision in the case of *Roche v Peilow* (1986) ILRM 189, the Court found that a solicitor’s professional practice contained such inherent defects that they have ought to have been obvious to give to any person giving the matter due consideration. The approach of the Courts in this regard is similar throughout common law jurisdictions. There is a deference and recognition of professional expertise and professional expert opinion but a recognition in rare circumstances that it is the proper for the Court to intervene. Kearns J stated “*Roche v Peilow* strongly suggests that the exception should only operate where a high onus is met and the defect, ignored or tolerated by the approved practice of a profession relates to an obvious risk or danger, which is in very marked contrast to the instant case. The exception is there to address an obvious lacuna in professional practice usually arising from a residual adherence to out of date ideas. It seems an inappropriate mechanism to find fault with medical practitioners for failing to warn of very remote risks which for that very quality cannot be regarded as obvious or ‘clear and present dangers’ even on due consideration”. Kearns J went on to say that “the application of the reasonable patient test seems more logical in

respect of disclosure. This would establish the proposition that, as a general principle, the patient has the right to know and a practitioner a duty to advise of all material risks associated with a proposed form of treatment. The Court must ultimately decide what is material." He also stated "the reasonable man, entitled as he must be to full information of material risks, does not have impossible expectations nor does he seek to impose impossible standards." However, it is true to say that the medical profession would not necessarily agree with the learned judge's remarks in this regard.

On the issue of causation as an element in the duty of disclosure Kearns J considered numerous cases from the common law jurisdictions but was particularly influenced by the Canadian case of *Reibl*. He said "in the first instance it seems to me that the Court should consider the problem from an objective point of view. What would a reasonable person, properly informed have done in the plaintiff's position?" As a second stage the judge stated that "the issue can and must be resolved by reference to the subjective test of what the plaintiff himself, again as a matter of probability, would have done." Interestingly, the judge found against the plaintiff on this issue of causation moving from the international perspective to a consideration of the development of medical jurisprudence in the area of disclosure of risks to patients.

LAW ON DISCLOSURE IN MEDICAL CONSENT IN MALAYSIA

In Malaysian medical jurisprudence, the standard of care expected of doctors in their professional practice had traditionally been determined by the *Bolam* test. In the cases of *Chin Keow v Government of Malaysia and Another* (1967) 2 MLJ 45 and *Dr. Chin Yoon Hiap v NG Nen Khoon* (1998) 1 MLJ 57 it was accepted by those Courts that the test for establishing negligence in diagnosis or treatment on the part of a medical doctor was indeed the *Bolam* test. However, there have been cases in the Malaysian Courts where *Bolam* was not followed. *Kamalam a/p Raman and Others v Eastern Plantation Agency (Johore) Stn Bhg ULU Tiram Estate Ulu Tiram, Johore and Another* (1996) 4 MLJ 674 and *Hong Chuan Lay v Dr. Eddie Soo Fook Mun* (1998) 7 MLJ *Bolam* was not followed. James Foong J in the last mentioned case stated "thus in considering whether a doctor has breached his duty in respect of the provision on information and advice, the Court rather than a body of medical opinion shall be the judge of this issue".

DEVELOPMENTS IN THE LAW IN MALAYSIA

The seminal case of *Foo Fio Na v Dr. Soo Fook Mun and Assunta Hospital* (2007) 1 MLJ 593 has brought the whole question of the *Bolam* test to a very critical point for Malaysia. The facts of the case are well known and related to the medical treatment of the plaintiff following an accident suffered by her in July 1982. The case was filed in 1987 and the plaintiff was successful in the High Court of Malaya in 1999. The *Kamalam* case was cited favourably in that judgement. The defendants appealed that decision to the Court of Appeal of Malaysia. The Appeal was allowed on a number of grounds relating to interlocutory applications, unpleaded particulars of negligence and the four year delay in judgement. The *Bolam* test was applied as the governing legal principle in the Court of Appeal. It is of interest to note the comments of Gopal Sri Ram JCA in the Court of Appeal hearing of the *Foo Fio Na* case that later came before the Federal Court. The judge stated that “*for the time being, the Bolam test maintains a fair balance between law and medicine. There may perhaps come a time when we will be compelled to lower the intervention threshold if there is a continuing slide in medical standards. But that day has not yet come*”.

The plaintiff patient then applied for, and was granted leave to appeal to the Federal Court of Malaysia (Appellate Jurisdiction) on a question of law. That question of law was posed to the Federal Court as follows: “*whether the Bolam test as enunciated in Bolam v Friern Hospital Management Committee (1957) 2 All ER 118 in the area of medical negligence should apply in relation to all aspects of medical negligence?*”. It is important to note the specific nature of the question of law posed to the highest Court in Malaysia. W.A. Dato’ Siti Norma binti Yaacob, Judge of the Federal Court delivered the judgement of that Court and noted that in granting leave to appeal to the Federal Court, the unanimous judgment of Steve Shim CJ (Sabah and Sarawak), Abdul Malek and Mokhtar Abdullah, FCJJ confined that question of law to the “*particular aspect of medical negligence [that] relates more specifically to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent or material risks of the proposed treatment*”. That judgement was reported at (2002) 2CLJ 11.

The Federal Court noted in great detail that the trial judge made observations in relation to the second operation performed on the appellant plaintiff. The Court said that “*this is a finding of facts and the law on appellate interference against findings of facts is well settled as to deter us from upsetting such a finding*”. The Federal Court also distinguished the facts in the instant appeal from the facts in the *Bolam* case.

The Court traced the history of the law regarding the application of the *Bolam* principle by the English Courts. It placed great emphasis on the judgements in *Sidaway* and *Bolitho*. The Federal Court noted that common wealth jurisdictions have declined to follow the *Bolam* case and the judgement of the Federal Court dealt in detail with the already cited Australian case of *Rogers v Whitaker*. Up to that point in the Federal Court's judgement, it did appear that the Court was leaning away from *Bolam* but only in relation to the standard of care to be provided by a doctor in the area of advices given to obtain informed consent. However, in an extremely important part of the judgement, Dato' Siti Norma Yaacob said: "*in the realm of diagnosis, treatment and the duty to warn, the ruling of the High Court of Australia in Naxakis v Western General Hospital and Another (1999) HCA 221 was able to settle the ongoing doubt which existed in Rogers v Whitaker, as to, whether Rogers was restricted to cases relating to negligent advice only.*" This part of the judgement as delivered appears to go beyond the question of law which the Federal Court had very clearly recognised was posed to it at the commencement of its judgement.

The Federal Court then reviewed the application of the *Bolam* principle by the Courts in Malaysia in medical negligence cases but also recognised that following the decision of *Rogers* in Australia in 1992, that conflicting judgements had been delivered in the Malaysian Courts "over the preference and application of the *Rogers v Whitaker* test to the *Bolam* test". The Federal Court noted that the *Rogers v Whitaker* test was fully endorsed in Malaysia for the first time in the case of *Kamalam* and that it was again applied in the case of *Tan Ah Kau v the Government of Malaysia (1997) 2 AMR 1382*. The reference by the Federal Court to Michael Jones's book on Medical Negligence 1996 edition, at page 95 is of importance. The Court stated that "*it seems to suggest that there is a distinction between the test of negligence based on the reasonable competent man and that of the ordinary skilled man. The former makes it clear that negligence is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor' and the latter places considerable emphasis on the standards which are in fact adopted by the profession. He emphasises that the point is for the Court to determine what the reasonable doctor would have done, not the profession.*". Jones is further quoted as stating that "*the Bolam test fails to make this important distinction between the reasonable competent doctor and the ordinary skilled doctor.*"

In an interesting reference to the Irish case of *Best v Wellcome Foundation Limited (1994) 5 Med LR81*, where Finlay CJ defined the "*function which a Court can and must perform in the trial of a case in order to acquire a just result, is to apply common sense and a*

careful understanding of the logical and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind”.

The Federal Court in its conclusions stated that “*we are of the view that the Rogers v Whitaker test would be more appropriate and a viable test of this millennium than the Bolam test*”. The Federal Court answered the question of law posed to it in the negative. It therefore clearly rejected the application of the *Bolam* test as applying in relation to all aspects of medical negligence.

It does appear from the question posed to the Federal Court and in its definitive answer that the *Rogers v Whitaker* test is now applied in determining the standard of care of medical doctors in the area of providing advice in obtaining informed consent. However, the reference to the *Naxakis* case which in Australia widened the application of the Rogers approach to diagnosis and treatment must be noted.

Application has been made to the Federal Court (Appellate Jurisdiction) by Dr. Soo Fook Mun for a number of orders, including that the judgment of the Court of 29 December 2006 be set aside or alternatively that the judgment be reviewed. A number of grounds for the application have been set out.

MORE RECENT DEVELOPMENTS IN AUSTRALIA

It is of course pertinent to this paper to consider the final report of the Committee chaired by Justice David Andrew Ipp in Australia on the law of negligence including medical negligence. The Ipp Committee recommended the tightening of the law of negligence in favour of defendants and away from plaintiffs and also that the standard of care should differ between two separate contexts: (a) in relation to the provision of information about treatment and (b) in relation to the treatment itself. This was in essence a recommendation to row back from the *Naxakis* extension to *Rogers v Whitaker*. However, it should be noted that the Ipp Committee expressly refused to recommend the reinstatement of the *Bolam* principle whilst favouring the test in *Bolitho*. The recommendations of the Ipp Committee in relation to the law of professional negligence have been enacted by statute in a number of the States in Australia.

Interestingly, the Court of Appeal in Singapore has also settled on the “*Bolitho* addendum to the *Bolam* test” in the *Dr. Khoo James* case.

THE CONSEQUENCES OF DEVELOPMENTS IN THE LAW OF MEDICAL NEGLIGENCE TO THE PRACTICE OF MEDICINE AND THE DOCTOR-PATIENT RELATIONSHIP

This review of the law in Britain, Ireland, Canada, Australia, Singapore and other common law jurisdictions together with the most recent developments in Malaysian medical law now brings us to the question of where Malaysia stands in relation to the standard of care in advising patients in order to obtain informed consent. At the outset of this paper I said that the theme was the balance between determining what is due care and skill of the medical profession versus the patient’s right to know. Indeed it is in that context that we must now address these developments.

The increasing national and international recognition of human rights finds strong expression in the rights of patients in relation to their medical diagnosis and treatment. Medicine by its nature should be an activity involving trust between the profession and the patient. Law and the Courts must always endeavour to protect a country’s citizens or subjects’ fundamental rights. Gopal Sri Ram JCA and Diplock LJ enunciated some of the concerns about what has been referred to as “defensive medicine”. This concern that doctors will be forced to carry out more extensive, unnecessary and expensive clinical investigations and tests for fear of being sued in negligence for missed diagnoses also resonates with the medical profession.

It is appropriate to ask the question as to whether the pendulum has swung from a doctor centred test of disclosure of risk to a patient centred test and whether this pendular swing has been too violent or extreme. Physicists tell us that a pendulum will always seek the point of least resistance and greatest stability. We must therefore ask has the pendulum swung too far in favour of the patient or has it merely swung to a point where the imbalance in favour of the doctor has now been properly set right.

In certain countries including Ireland the increase in the number of medical negligence suits against doctors and the size of awards created difficulties for the healthcare systems. In Ireland in the early part of this decade, one of the indemnity

organisations set its annual subscription premium for obstetricians at €500,000 (approximately RM 240,000). A State indemnity scheme has been introduced recently in Ireland mainly in response to this problem but it has not yet fully addressed the difficulties that have arisen from the level of litigation and the size of awards by the Irish Courts in medical negligence cases.

The maintenance of trust between doctor and patient encompasses the need for accountability on the part of the profession. Patient autonomy or the right to self-determination and involvement in decision making, has gained strength in the past decades. There must be a recognition of both rights and duties on the part of patient and the doctor. Yet there is an uneasy relationship between medicine and law. Medical care is based on trust, albeit in a relationship of unequals, while the adversarial litigation process is based on a healthy and necessary mistrust. Therein lies the intrinsic tension even though both medicine and the law strive to serve the best interests of the patient.

In many countries there have been proposed reforms to the law on medical negligence including active management of cases, pre-action protocols, early exchange of expert reports, procedures to deal with small claims, structured settlements and the introduction of tables of awards for injuries for judicial guidance. Alternatives to legal action have also been mooted, including efficient complaints procedures, clinical risk management programmes, alternative dispute resolution (mediation and arbitration) enterprise (rather than individual practitioner) liability schemes, no fault compensation (particularly for children injured through brain hypoxia at birth), and pre-litigation screening to exclude any case without *prima facie* merit. However, none of these changes addresses the basic question about what can happen to trust between doctor and patient if an excessive adversarial approach is taken.

Solutions lie not only in reform and partial replacement of the tort system but also in a positive education programme for doctors, patients, lawyers, judges and the media in the area of medical negligence. Greater professional accountability, continuing professional education and reaccreditation procedures will also have a role. Rationalisation of arrangements for compensating victims of medical accidents is also required. Such a system is available for example in France. Only thus can a fair and balanced approach to transparency and accountability of professionals be

achieved whilst maintaining a caring and competent delivery of healthcare with a rebuilding of trust.

CHANGES IN THE REGULATION OF THE MEDICAL PROFESSION IN THE UNITED KINGDOM AND IRELAND

The recent UK White Paper presented by the Secretary of State for Health in February 2007 and entitled "Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century" is indicative of the thinking of government bodies in the area of regulation of the medical profession. That White Paper recommends a number of innovative measures to ensure continuous fitness to practice of doctors. Similarly in Ireland in the recently enacted Medical Practitioners Act 2007 the introduction of a lay person majority on the Medical Council together with competence assurance schemes and revalidation procedures indicates that there will be a diminution in self-regulation by the medical profession.

MALAYSIAN MEDICAL JURISPRUDENCE AND HEALTHCARE

Malaysian medical jurisprudence is at a crossroads in relation to the standard of care in medical diagnosis, treatment and advices and also as to the weight to be given to the evidence of the medical expert witness. The recent Federal Court judgement has moved medical jurisprudence away from the *Bolam* principle. It has certainly adopted the *Rogers and Whitaker* test in relation to advices to be given to patients. It also does appear that the judgment has not applied this test to diagnosis and treatment notwithstanding its reference to the *Naxakis* case. But this reference in the Federal Court judgment has unfortunately introduced a degree of uncertainty for the future. Whether Malaysia will extend the *Rogers and Whitaker* test to diagnosis and treatment or whether it will, like Australia, restrict that test most definitively and clearly to the giving of advice only is one critical decision for the future of healthcare in Malaysian society.

CONCLUSIONS

On the one hand it must be recognised that the reinstatement of the *Bolam* test as part of Malaysian medical law is improbable. The advancements in medical science and interventions, the greater educational levels of the patient population and their

increased expectations and questioning of the medical profession, together with the patient's right to information about their healthcare as a basic human right have all contributed to this shift internationally in the law on consent. Judicial and State oversight of medical professional practice has evolved and will continue to evolve.

On the other hand, the emergence of medical law that will stifle the advancement of medical science and care, that will lead to unnecessary defensive medicine and unsustainable medical litigation and that will be financially costly to the healthcare system through high indemnity or insurance premia will not be a positive development for Malaysian healthcare. The doctor-patient relationship, based on earned trust and responsibility, is worthy of nurture in a caring healthcare system and should be considered at least as important as any technological advancements.

Is there a position of stability that can ensure patient rights while encouraging medical scientific advancement and care and fostering the doctor-patient relationship? These two apparently stark choices are comprised of difficult and problematic issues requiring careful consideration and prudent policy decisions. The two swings of the pendulum are not mutually exclusive and do not preclude a stable and compatible solution serving both patient and medical needs. What is now required is an informed and reasoned debate by the relevant authorities and interested persons of where the pendulum should swing, and come to rest (until it must by nature move again), to achieve the proper balance between medicine and law in the best interests of the patient whilst giving full encouragement and support to a properly regulated and competent, caring medical profession.